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What Makes Men Talk About Health?

SALLY BROWN

ABSTRACT

This paper compares two research projects which explored men's beliefs about their health. The concern of the paper is not with the findings themselves, but with the methodological issues concerned, in particular, the issue of interviewing men about health. The paper first discusses relevant issues from the literature concerning gender and interviewing. It then goes on to describe the two research projects, both of which involved interviews with men, firstly about health in general, and secondly with men who had had a heart attack. The experience of the researcher in each project was quite different, and the paper discusses possible reasons for this, including the part played by gender. It concludes by suggesting reasons for men talking, or not talking, about health the way they do.

Introduction

The influence of gender on the research process has been the subject of attention particularly from a feminist perspective, and with a focus largely on documenting the experiences of female researchers interviewing women. This paper focuses on the experiences of a female researcher interviewing men, and examines the influence of gender on the interview. It compares two research projects which explored men's beliefs about their health. The first project comprised 17 interviews with men selected from GP lists, where the broad topic was men's views of their own health and health needs. The second project comprised 24 interviews with men who had had heart attacks, again the interviewees were recruited through GPs. The purpose of this paper is to discuss the issues raised by interviewing men about health, as the results of the two projects were very different in terms of the success of actually getting the men to talk about health. The paper begins by outlining themes from the literature on gender and interviewing which are pertinent to this paper, and then goes on to present and discuss the two research projects. The paper discusses status relationships in the interview process, in terms of the role of gender and the role of 'professional', but it is argued that a simple gendered dichotomy does not explain, by itself, the complexity of research relationships. Subject matter and the interviewee's perception of the role of the researcher were found to be influential. The paper concludes by discussing reasons for men talking the way they do about health.

Themes from the Literature

Oakley (1981) raised the issue of gender in interviewing in terms of the role of a female interviewer in interviewing women. This research raises the question of gender in terms of a female interviewer interviewing men. As McKeganey and Bloor point out, 'documentation of the influence of gender on sociological research has been undertaken almost entirely by female researchers' (1991, p. 195). Finch (1984) had earlier pointed out that the gender of the interviewer was an important but relatively overlooked methodological issue, although since then it has been addressed from a number of viewpoints. Much of the debate has been about female interviewers and female respondents (Oakley, 1991; Finch, 1984) although some has addressed cross-gender issues of female interviewers and male respondents (Hunt, 1984; Warren, 1988). At the same time, research on health beliefs has focused largely on women (Locker, 1981; Blaxter & Paterson, 1982; Blaxter, 1983; Calnan, 1987) and where there has been a focus on men, it has been argued that 'work on male health beliefs is rare' (Mullen, 1993, p. 28). One reason for this is provided in the assumption made by Locker (1981) that women would be more closely acquainted with issues of illness in the family, and as White argues, where researchers consider men, 'most focus on the medical aspects of male-specific illness' (1999, p. 67), rather than the male aspects. For the purposes of this paper, the focus is on the research process rather than the findings, and thus the literature discussed below does not concern itself with the research on men's health beliefs; unfortunately, this is beyond the scope of a paper of this length. In their brief review, McKeganey and Bloor (1991) put forward three themes in the literature on gender and sociological research. Firstly, gender as a catch-all concept; secondly, gender as a negotiable concept; and, thirdly, gender as an overlooked concept. McKeganey and Bloor suggest that gender has been used as a catch-all concept whereas in fact age or social class might be key influences in processes. They cite Easterday *et al.* and their suggestion that female researchers are seen as 'powerless and non-threatening' (1977, p. 344) and therefore have few problems negotiating access to research settings, but they argue rather that this is more to do with low-status research than gender. When Dingwall refers to 'personable young women' (1980, p. 881), it is the combination of

gender, age, and personality which makes for empathetic interviewers rather than gender alone, especially since he suggests that such researchers be used in studies of 'powerful older men' (1980, p. 881) where they might be seen as unthreatening and thus obtain indiscretions and revelations. Morgan also points to the assumption that women 'are better able to put their subjects at ease, to establish rapport' (1986, p. 43). Finch documents her experience of being a female researcher interviewing women. She describes how she found establishing rapport to be much easier than she had expected, with the women talking openly to her. She suggests that 'they had found this kind of interview a welcome experience, in contrast with the lack of opportunities to talk about themselves in this way in other circumstances' (1984, p. 74). She argues that the loneliness of the women, which stemmed from the structural position of women and their consignment to the domestic sphere, meant that they welcomed the opportunity to talk. She suggests that the difference between men and women in this situation is that men are less likely to accept questions about their lives than women, because women become more accustomed to it as part of their life, especially once they become mothers. McKee and O'Brien (1983) found that, compared with interviews with women, the interviews they undertook with men were comparatively brief. In addition, they felt that men were much less expressive about feelings and emotions. Cunningham-Burley found that when she interviewed men and women together for her study of grandparenthood, the women were talkative whereas she had a sense that the men were indifferent, although they could be chatty after the interview. In contrast to the women, men gave one or two word answers which were not revealing of personal data. She found that 'it was hard to get the men to talk' (1984, p. 327) but, when they did, many of them had a joking style, and treated serious questions lightheartedly. Warren comments that 'the focal gender myth of field research is the greater communicative skills and less threatening nature of the female fieldworker' (1988, p. 64), which seems to capture both the idea that gender is influential in terms of communicative skills, and also Scott's cross-cutting idea that power and status, in terms of less threatening nature, are key factors. This feminist approach to research has tended to emphasise the commonality between women and, as Finch argues, the shared subordinate position of female researcher and female interviewee means that, often, women interviewees will be talkative and revealing because they are talking to another woman; 'a feminist sociologist doing research on women actually shares the powerless position of those she researches' (Finch 1984, p. 86). However, Chandler (1990) shows in her research with Navy wives that merely being the same gender is not necessarily a passport to empathy and greater understanding, as both culture and assumptions about power influence the way the interview goes. It would seem, then, to be unwise to make assumptions about gender and interviewing based on a simple notion of the gender of the researcher and the gender of the researched, without also looking at issues of power and culture as rather more complex factors than unidirectional ones.

Secondly, McKeganey and Bloor refer to discussions of gender as being negotiable. Hunt (1984) argued that she negotiated a status of honorary male in her work, and was seen as androgynous by displaying both masculine and feminine characteristics, which gained her a trustworthy gender identity. In contrast, Warren and Rasmusen regard gender 'not as an object of fieldwork negotiation, but as part of the structural grounds upon which negotiation takes place' (1977, p. 9). McKeganey and Bloor suggest that in fact Hunt and Warren are discussing different stages in a dynamic research process, and that at various times gender can be an assigned status or an opportunity for negotiating fieldwork relations. Hunt argues that gender is a fundamental aspect of field relations where there is a split between masculine and feminine domains, which suggests that one gender doing research amongst the other has to negotiate an acceptable identity (for example, Bloor as 'Favourite Uncle', see McKeganey & Bloor, 1991, p. 201), especially where it is not usual to find them there. McKee and O'Brien discuss power relations between men and women in the context of the interview situation and, having described a number of instances where they felt threatened or were on the receiving end of verbal abuse and offensive remarks, argue that gender relations have to 'incorporate the hierarchical power and control men have in society and the public domain' (1983, p. 159). Scott (1984) suggests that assumptions about gender cross-cut dimensions of status, and it is difficult to pick out which is most influential. Thus, negotiating an acceptable identity can be limited by assumptions about power.

McKeganey and Bloor's final theme relates to the invisibility of gender, where 'males are treated as the normal subject for research' (1991, p. 197), the 'male-as-norm bias' (Scott, 1984, p. 177) meaning that questions of male gender are overlooked. In the reflexive literature on interviewing, in particular, this would certainly seem to be the case; as the literature discussed in this paper demonstrates, reports from female researchers writing about their experiences considerably outweigh those from

male researchers. Not only, then, are males treated as the normal subject for research, they are also regarded as the normal and largely unproblematic gender for conducting research. A further theme can be added, that of gender and access. Both Cornwell (1984) and Crawford (1984) found it difficult to find men who would be willing to become involved in their research. In Cornwell's study, which took place in the East End of London, she interviewed several members of a number of families. She did not seem to have problems finding women to participate in her study, but men were much more reluctant, with several refusing to take part. She eventually recruited volunteers by going to a Residents' Association meeting. Having recruited men, she then found that the interviews themselves were more difficult: It was noticeable that the atmosphere in the interviews with all the women was easier and the interviews were accomplished with less difficulty than the interviews with the men: there was a familiarity between myself and the women, and an understanding of how to approach each other which did not occur with the men. The men—quite literally—did not know how to talk to me: they did not know whether or not to swear or tell jokes and also had very little idea what to say about personal matters. (1984, p. 13) This raises the question of whether the gender of the interviewer is the key factor, or whether the topic is more influential: are the men reluctant to join the research because the interviewer is female? Are they more difficult to interview, because the interviewer is female? Or are they unwilling to talk about a personal topic such as health? Cornwell's experience seems to suggest that it is a combination of factors: men do not like talking to a woman, or feel unable to talk to a woman, and also men do not like talking about health. Crawford (1984) also found that men were less willing to take part in interviews, with two-thirds of his interviewees, recruited via a snowballing sample, were female, despite his attempts to ensure that he had a demographically representative sample and not one that was restricted to established networks. Although two examples cannot be used as conclusive proof, it would seem that the gender of the researcher is not the critical, or only, reason for men's reluctance to participate in research about health. Neither McKee and O'Brien (1983) nor Cunningham-Burley (1984) are clear about the extent to which men volunteered to become involved in their research. The problems they experienced in recruiting men, which led them to recruit them via women (mothers, grandmothers), may also have meant that the men felt coerced or obliged to take part, rather than being true volunteers. This may account for some of their reticence in the interview, and some of their 'non-standard' behaviour, e.g. walking in and out of the room during the interview.

Thus the literature would seem to indicate that not only have men not been the subjects of health beliefs research to the same extent as women, but that they are also more difficult to access and, once accessed, to interview. Interviews would seem to be characterised by problematic gender relations, and by lack of openness and revealing conversation.

Men's Health Needs—Project One

The first project attempted to explore men's views of their health and health needs. The focus on middle-aged men was chosen because it was felt by GPs who were interested in the project that middle-aged men were an 'invisible group'; morbidity and mortality data suggest that men aged between 45 and 65 have health problems, and yet they do not attend GP surgeries very much. Thus the intention was to interview men to find out what they felt about their health, how they saw their health needs, and perhaps how they felt any unmet needs could be met by GPs. Men were selected from the lists of two practices that participated in the research, one an urban practice and one semi-urban with a large rural catchment. Men were sent a letter explaining the research, and asking them to return a slip to the university if they were willing to be interviewed. Half the addressees from the semi-urban practice and a quarter from the urban practice returned slips indicating willingness to take part. Following this, they were contacted by the female researcher to arrange the interview. The interviews took a semi-structured approach and took place in men's homes. They lasted between 25 and 50 minutes. The interviews were taped, with the permission of the interviewees, and later transcribed. Most took place with only the subject present, but in three cases the subjects' wives remained in the room. In one case this was useful because the wife was able to remind her husband of details which he had forgotten; in the other two cases the wives had little active involvement, except to confirm their husbands' statements when prompted (by the husbands). Seventeen interviews took place, with men ranging in age from 48 to 65, all but one of whom were married.

Men After Heart Attack—Project Two

The second project looked at the impact of a heart attack on men. Twelve practices took part in the project, and sent out a short questionnaire and letter on behalf of the researcher to men on their lists who had had a heart attack in the previous two years. At the end of the questionnaire was a slip which

could be completed if the respondent was willing to be interviewed. In all, 65 per cent (72) of the questionnaires were returned and, of these, 47 indicated a willingness to be interviewed. Three of the 47 could not be contacted, and one had changed his mind. From the 43 available and willing, a purposive sample of 24 men was selected, based on ensuring a range of age, different marital status, and socio-economic factors amongst interviewees. Men aged between 41 and 85 were interviewed. Most were married, two were single, two divorced and two widowed, although all but one of these men had either remarried or had a close female partner. The interviews took place in the men's homes, and again were taped with the consent of the interviewees and later transcribed. In nine of the interviews wives/partners were present to a varying extent, and contributed to the interview. Interviews lasted between 45 and 90 minutes. Again, they took a semi-structured approach although this of necessity became more flexible once it was realised that the wives were making valuable contributions to the findings.

In each project, the intention with the recruitment strategy was to ensure that each group had a spread in terms of age (although Project One focused on middle-aged men, aged 45–65, and Project Two had no age restrictions, in fact most interviewees for Project Two were between mid-40s and mid-60s), in terms of marital status, and in terms of socio-economic group. The groups were not 'matched' in the sense of allocating 'controls', but did reflect broadly the same mix of characteristics.

Men Talking About Health

In Project One of the research, the interviews themselves varied greatly in length and in success, if one of the measures of success was getting men to talk openly and at length about their health. It can be dif. cult to get men to talk about health when they start from the position of 'I haven't got much to say because I never go to the doctor'. Others commented that they had no complaints about the doctor and therefore had little to say. Several of the interviewees gave very abrupt answers and could or would not elucidate their views. It is possible that some men may have felt uncomfortable discussing personal matters with a female interviewer, although they would have been made aware that the researcher was female at the stage of telephoning to arrange the interview. In some cases, it seemed that the men genuinely had little to say because health was a topic to which they gave little or no consideration. They seemed to regard health as an issue only in the context of seeking care when ill and going to the doctor; therefore, if they did not go to the doctor, or did go but had no complaints, they had nothing to say about health. For the most part, they regarded themselves as not in need of any health care, and did not see themselves as having health needs at that moment. Thus one of the preliminary conclusions to the research at this stage was that it was dif. cult to get men to talk about health in any detail or at length.

With the Project Two interviews, each one began with the interviewee being asked to 'tell the story' of the heart attack, and to talk about what had happened leading up to the attack. This approach meant that the men from the outset were being asked for their 'story' and, as such, this may have meant that they felt that their personal views and feelings were significant and thus were encouraged to be more open. It was interesting that many of them at the end of the interview asked whether they had talked about 'the right things', indicating that they had not expected to talk so much about themselves, thinking more that the interview would be about doctors and hospitals. In Project Two, then, the men were much more willing to talk about their health in great detail and at great length. In Project One, it was sometimes a struggle to get them to talk for half an hour. A number of potential reasons for this difference are discussed below.

Men are not used to talking about health, as it is not normally part of their day to day discourse: the two sets of interviews produced two different experiences, the first round seeming to indicate that Finch (1984) is right to say that men do not find it easy to answer questions about themselves, and the interviews being quite dif. cult. The second round, however, was similar to Finch's experience, although hers was same-gender and this was cross-gender—the men seemed to enjoy talking about themselves, and on a number of occasions commented that it was nice to have someone to talk to. It could be suggested that one reason for this is that the men have suddenly found themselves confined to the domestic sphere, and feel the loneliness in contrast to being in the social world of work. McKee and O'Brien say that researchers must take into account 'the complex and contradictory ways in which both women and men are contesting the status quo' (1983, p. 159), which allows space for contradictory findings in research projects. McKee and O'Brien described their experiences of threatening behaviour during their fieldwork with men, and Green *et al.* (1993) discuss instances of sexual harassment during the research process. However, my experience is very different as my

interviews never involved any abuse or threat and, indeed, did not appear to be an expression of male power and dominance. McKee and O'Brien's experiences might relate to their topic, which was interviewing lone fathers about parenthood, and in terms of contesting the status quo between men and women, many of the men had negative feelings about women which could have influenced the threatening nature of some interviews. Green and her colleagues were involved in a number of projects exploring aspects of sexual behaviour, which may have been seen by the men involved as an opportunity to talk about sexual matters in particular ways, especially in settings where female researchers were observing groups of young men, who took the opportunity to show off in front of their friends. Perhaps because my interviews were in the private sphere, to which, moreover, many men had relocated as a result of their illness, the dominance of the public domain was diminished. As with Finch above, the shift from public to private, from work to domestic, may involve a shift in gender roles which makes 'health talk' more acceptable for men. There are similarities with Project One interviews and those of Cunningham-Burley (1984), where the men in both cases often gave very short answers, and in many cases did not seem to want to reveal personal information. In addition, in Project Two, several of the men talked about very serious matters, then laughed at the end of their comment. It could be argued that jokiness and the use of humour diverts the focus on issues which otherwise could be difficult to deal with, such as death and loss. Men in both rounds of interviews seemed to see health as 'women's business', particularly in terms of their expectations that women would 'look after' them. The wives of men in Project One in many cases made appointments at the doctor for the men, and made the decisions about diet. Some of the men made explicit comments about it being a woman's job to take care of the health of the family, mainly because they became accustomed to going to the doctor with children whereas men did not go so often and therefore did not like going. Similarly for the men in Project Two, decisions about changes in diet had been made and implemented by wives, and when men talked about diet, they all said 'we' have changed rather than 'I' have changed. In addition, men's activities were monitored by wives, and decisions about calling the doctor were made by wives. Thus it may be that where health is women's business, and part of a female discourse, men who do not have any health problems do not need to think about it. When men have health issues thrust upon them by virtue of suffering a heart attack, it is still women's business but it also becomes part of male discourse.

Men do not wish to seem vulnerable and therefore in Project One did not want to be open, whereas in Project Two it was acceptable because a serious and recognised health event had happened: in Project One, it seemed that many of the men genuinely had little to say because health was a topic to which they gave little or no consideration. In Project Two, the acceptance rate of interviews was higher (i.e. more men responded positively to the letter inviting them to take part in the study) and the interviews themselves were generally much more successful. They lasted longer, and men were much more forthcoming, talking at greater length and in more detail than in the first phase. The interviewer was the same person in each set of interviews, so it can be suggested that gender is not the crucial issue. Rather, the difference is in the topic. Although both rounds of interviews were about health, in the first round the men were not selected on the basis of having any particular illness, and found it difficult to talk about health, saying things like 'I haven't got much to say about health because I'm never ill'. In the second round, the men had a specific condition to talk about, in the heart attack, and had a focus for their talk about health. Both Cornwell (1984) and Calnan and Williams (1991) found that people are more willing, and find it easier, to talk about illness rather than health. Herzlich's (1973) conception of health as the absence of illness suggests something of a neutral state, where people do not think about their health as they do not have to, health only becomes important as a consequence of it being attacked by illness. It is suggested that the two rounds of interviews demonstrate this to be true for men—if they do not have a reason to focus on their health, it tends to be taken for granted, and in a mechanistic and functional way. Once they become ill, their health is brought sharply into focus and becomes a topic for consideration and discussion. In addition, because a heart attack is an event that is confirmed as real and serious by health professionals, the men have acceptable reasons for talking about their health and themselves; it is not a matter of personal weakness, but a serious event validated as such by professionals. Stewart and Sullivan (1982) show that legitimisation from physicians is a necessary part of the process of being 'allowed' to be ill by people around the patient, particularly in cases where symptoms are unclear or not obvious. This transformation of sickness into disease as a result of diagnosis is shown by Robinson in his study of multiple sclerosis patients. He describes how one patient explained the process of diagnosis when he went to the doctor with a range of symptoms and, on seeing the doctor, 'was treated for depression, after which I did become depressed' (1990, p. 20).

Finally, it should be noted that in the research discussed here all the men were contacted directly and were volunteers—one limitation of this may be that it is a self-selected sample who, by virtue of their willingness to be interviewed, are more likely to be open and talkative, but given the difficulties of the first interviews, it could be argued that the men may have been self-selected but they were not chatty. However, the nature of the recruitment process may be one way of accounting for the difference in experience between this research and some of that discussed above, particularly McKee and O'Brien, and Cunningham-Burley.

Conclusion

Morgan argues that 'to adhere to a dichotomous construction of gender differences is to run the risk of reproducing, often unconsciously, stereotypical assumptions about men and women, and of failing to do justice to the complex, paradoxical and sometimes contradictory understandings of gender in contemporary society' (1986, p. 35). The experience of the two research projects discussed above would confirm the accuracy of this quote, as the assumptions about male inexpressiveness which were confirmed by the first round of interviews were demolished by the second round. Warren's comment seems appropriate, when she says that we need to understand 'the web of data, self and discourse' (1988, p. 65) when we approach fieldwork and writing. This paper has argued that gender is a factor which must be taken into account in the research process, but that it is more complex than a dichotomous view of gender would allow. Status relations and subject matter are also key influences on the interview process, and gender is one strand of a complex web. Further to Hunt's notion of negotiated androgyny, I would suggest that for my interviewees gender was not the key factor, and many of them may have seen me as androgynous. I would argue that the key factor is power and professionalism, and that many of the men in the second study in particular saw me as a professional. Several showed me their medicines, and I was asked questions such as 'are you going to be a surgeon when you've finished this?' or told 'you'll know about that with your medical training'. It is suggested that for men who have recently had the experience of being examined and questioned by members of the medical and caring professions of either gender, another person appearing to ask more questions is seen in much the same light. The two sets of interviews suggest that gender is not the key factor, but that expectations about a questioning relationship between patient and professional may be.

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